STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

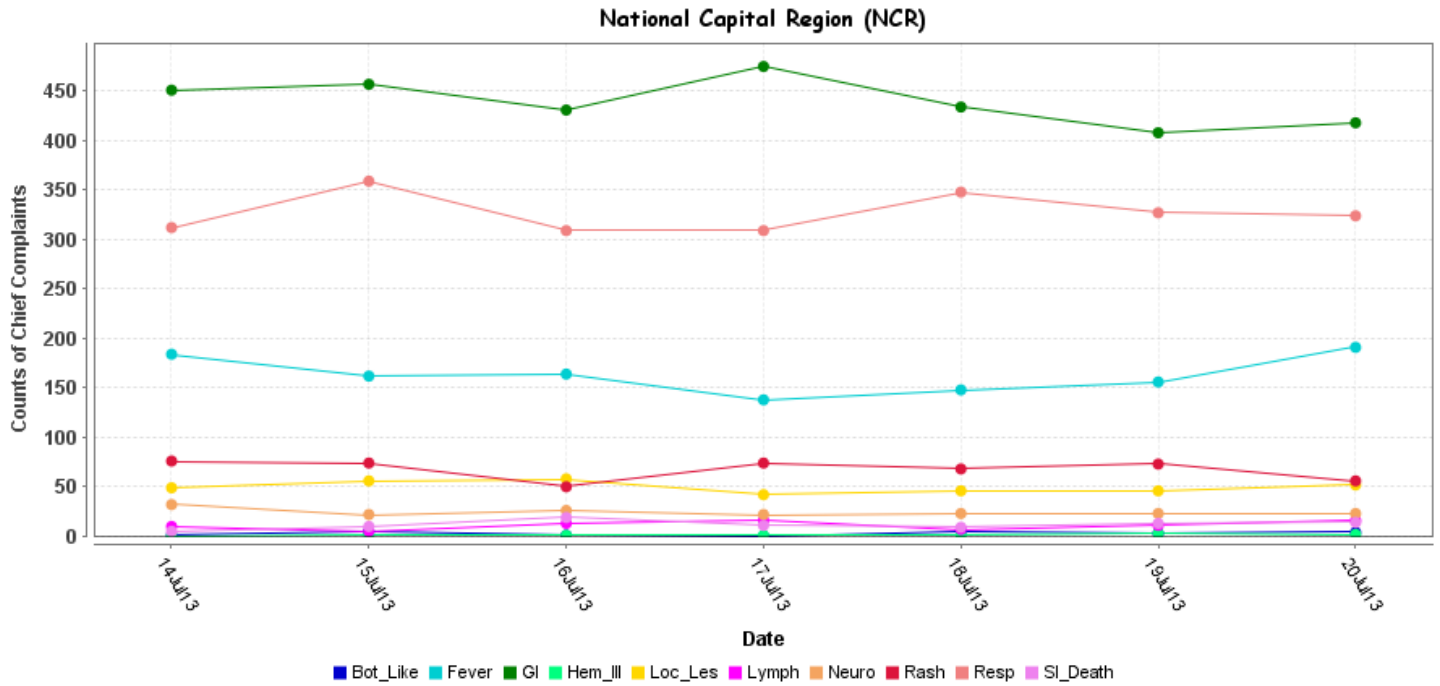
July 26, 2013

Public Health & Emergency Preparedness Bulletin: # 2013:29
Reporting for the week ending 07/20/13 (MMWR Week #29)

CURRENT HOMELAND SECURITY THREAT LEVELS

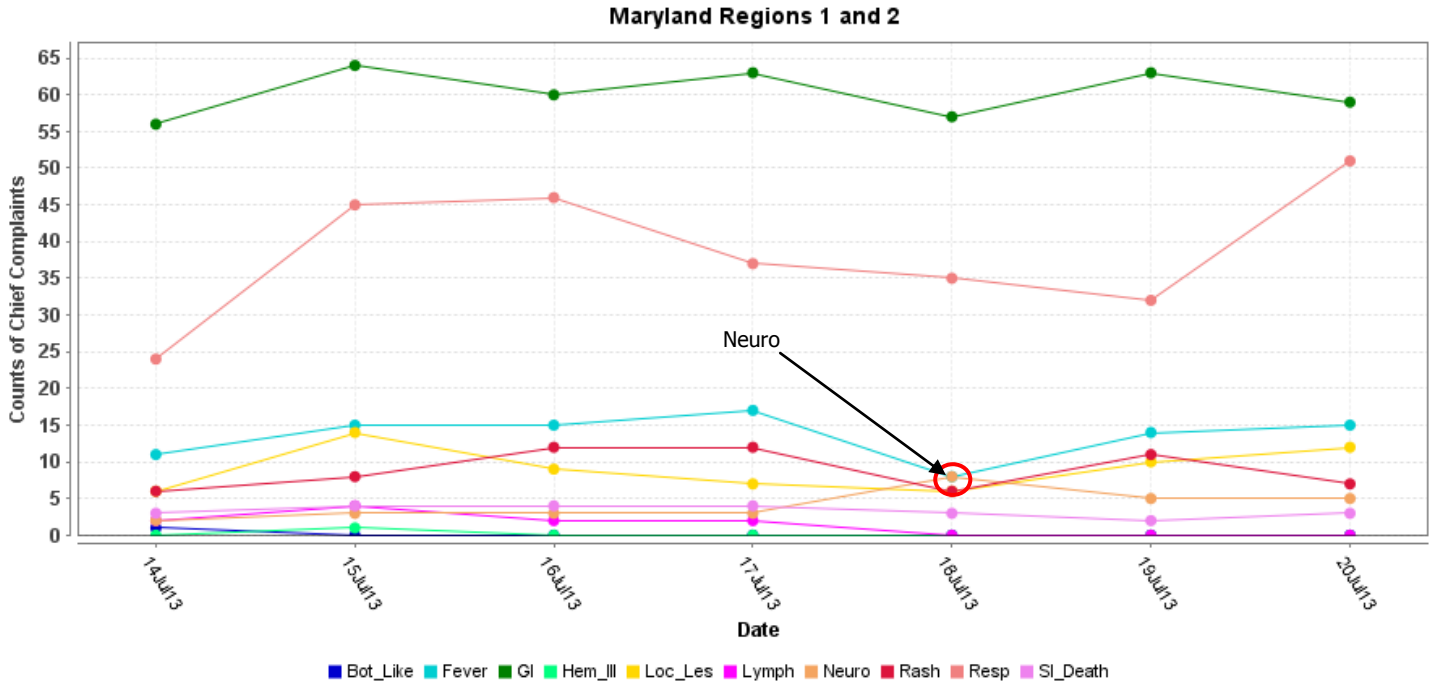
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

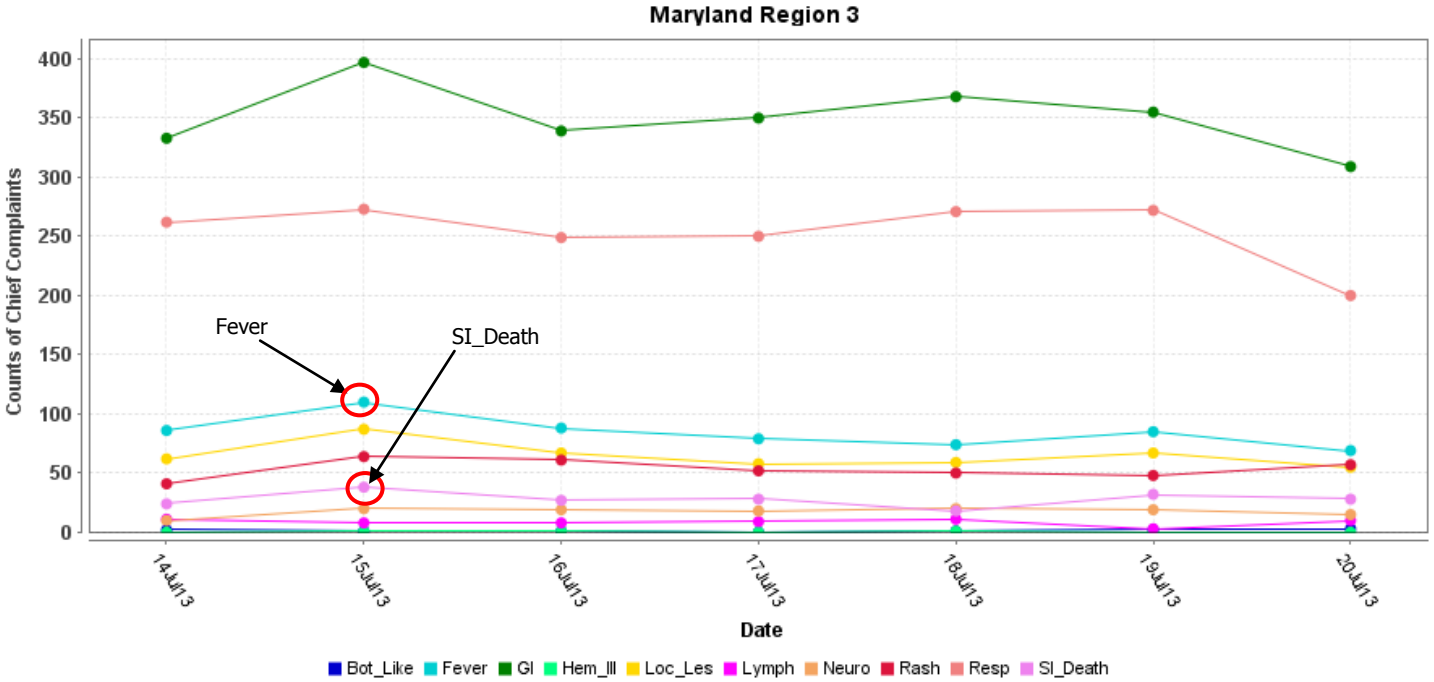


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

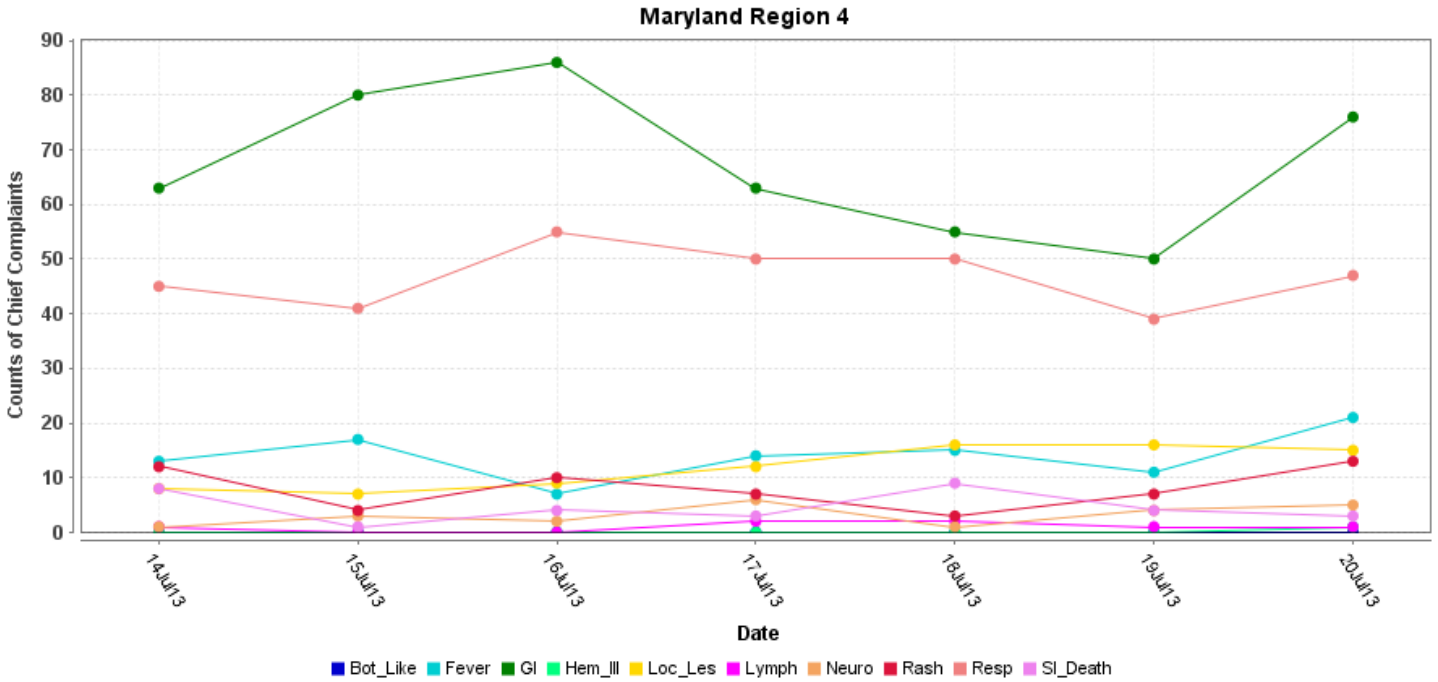
MARYLAND ESSENCE:



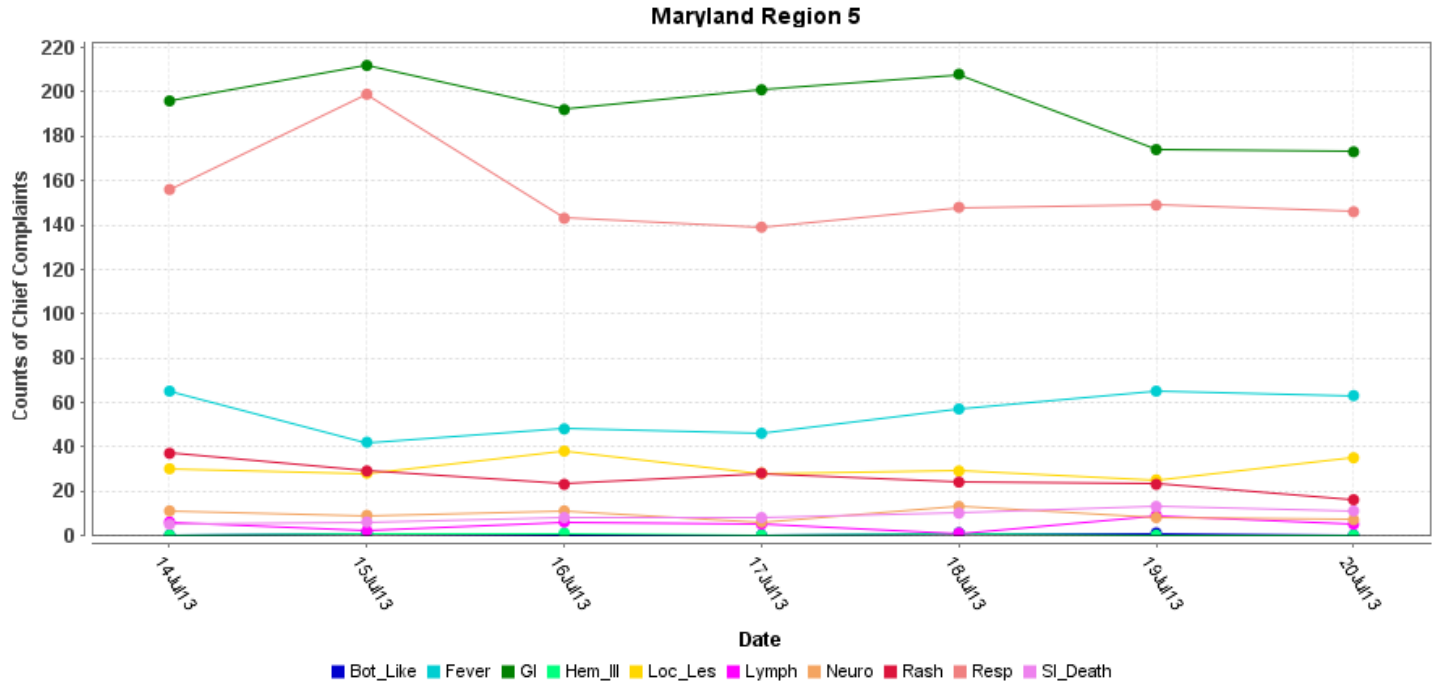
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



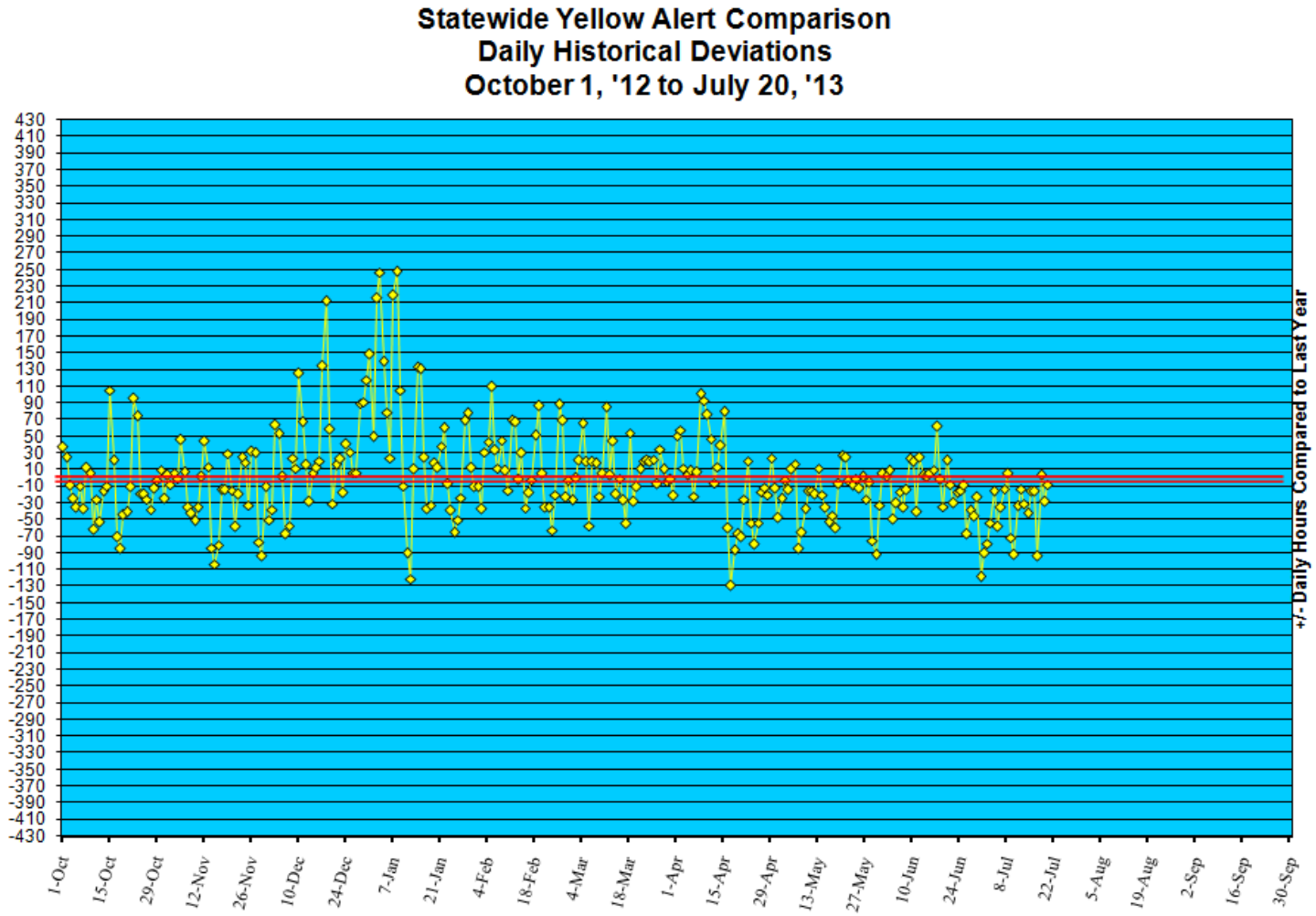
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in June 2013 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (July 14 - July 20, 2013):	8	0
Prior week (July 7 - July 13, 2013):	2	0
Week#27, 2012 (July 16 – July 22, 2012):	20	0

1 outbreak were reported to DHMH during MMWR Week 29 (July 14 – July 20, 2013)

1 Rash Illness Outbreak
1 outbreak of SCABIES in a Nursing Home

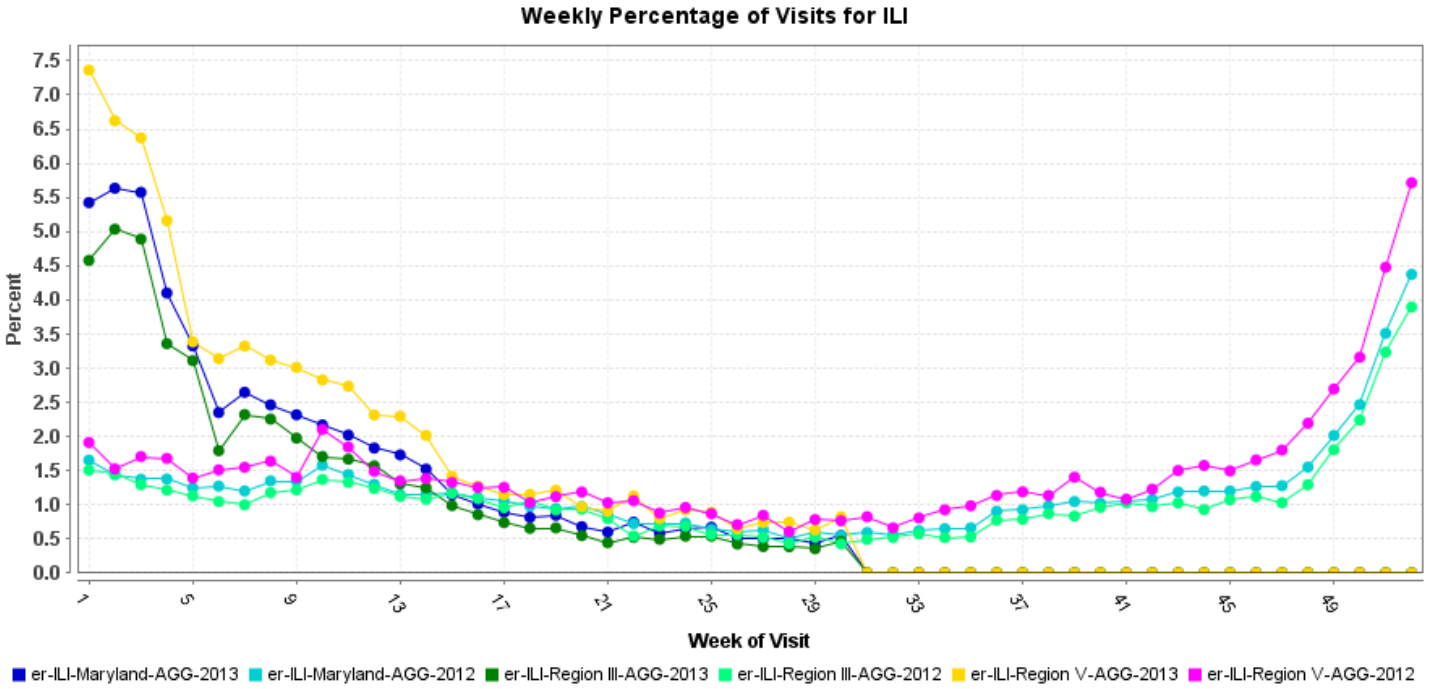
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May.

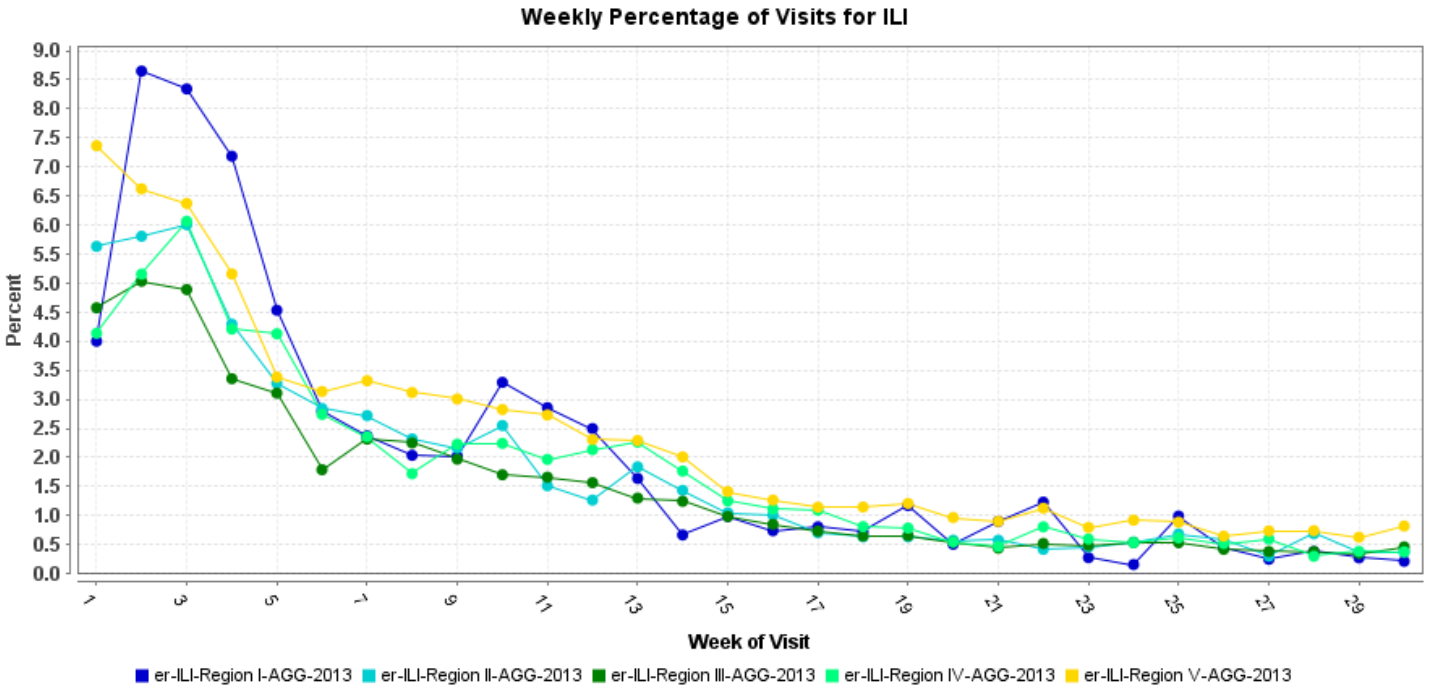
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



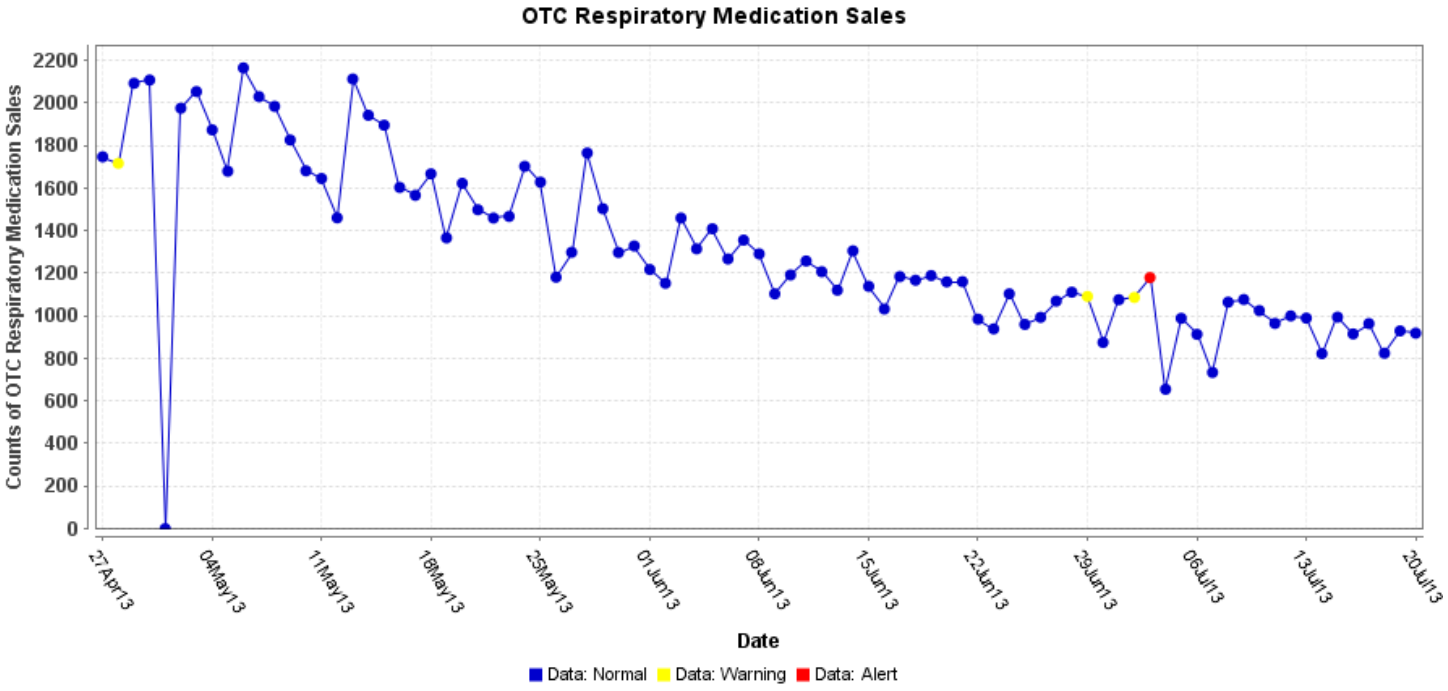
* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of July 5, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 633, of which 377 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 60%.

AVIAN INFLUENZA, H7N9, HUMAN (CHINA): 20 July 2013, A 61-year-old female has been confirmed as a case of H7N9 avian influenza virus infection in Beijing by Beijing CDC on Sat 20 Jul 2013. She is a resident of Langfang Shi, a city between Beijing and Tianjing [in Hebei Province]. She developed fever on 10 Jul 2013 and was diagnosed as a case of severe pneumonia on 13 Jul 2013. She was transferred to Beijing Chaoyang Hospital on 18 Jul 2013. The patient is in serious condition and being treated.

NATIONAL DISEASE REPORTS*

LISTERIOSIS (CONNECTICUT): 19 July 2013, A man in his 30s originally from Ravno, Bosnia and Herzegovina traveled with his wife and children to his home town for a family event. The man had no significant past medical history. While there, the family visited a local zoo, hiked, and visited ta cheese factory (which employs 4 people) outside Ravno. The factory uses cow and goat milk for producing cheese, and all cheese preparation is manual. Two days after this visit, the patient started having a low grade [fever]. Five days later, upon returning to the USA to Connecticut, he presented to an emergency room with a fever of 101 F [38.3 C], significant headache, and some watery diarrhea. Because of sensitivity to light and some neck rigidity, a spinal tap was performed. The cerebrospinal fluid (CSF) culture grew Listeria monocytogenes. The following day, his wife was admitted with a similar clinical picture but with a less severe headache, and her CSF culture also grew L. monocytogenes. The factory also reported 3 more cases of a similar disease locally over 2 weeks. Both milk sources, goat and cow, were cultured, and the goat culture was positive for L. monocytogenes. Cheese production was temporarily halted for "terminal cleaning." (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (NEW YORK): 18 July 2013, At least 2 people who went swimming 23 Jun 2013 at Nathaniel Cole Park were treated for E. coli binfections, Broome County [New York] health officials said Wednesday [17 Jul 2013]. In the wake of the confirmed E. coli cases, county park officials have increased the frequency of water testing at Cole Park's lake to every 3 days from its regular 2-week cycle. Only one test on 28 Jun 2013 showed an elevated E. coli bacteria level, which officials said could have been caused by heavy rain in preceding days. All others were within normal levels for coliform bacteria, which can cause diarrhea or others illnesses. County officials said the latest results from water samples taken Wednesday [17 Jul 2013] are expected Friday [19 Jul 2013]. E. coli can be linked to fecal contamination in swimming areas. The bacteria also could be contracted from contaminated food, including undercooked meat, or person-to-person contact. An estimated 800 others swam in the lake on 23 Jun 2013, and thousands in following weeks, with no other confirmed cases, county officials said. The 2 people with E. coli are recovering, according to a news release. The county would not identify them or the extent of illnesses in order to respect their privacy. "Symptoms were 1st reported to the Health Department and then investigated over a period of time thereafter," said Bijoy Datta, deputy Broome County executive. "Cole Park and all other county parks remain safe for swimming and other recreation." County officials did not provide an exact timeline of what happened in the 3.5-week time period from 23 Jun 2013 until the public was informed, although the lapse can partially be explained because the health department was not immediately aware of the infections. "We are committed to the health and safety of our residents and those who use our parks and waterways," Datta said. "We are also vigilant in providing timely and accurate information to ensure public health and safety are not compromised." In late spring 2011, dozens of swimmers at Greenwood Park [Broome County, New York] developed non-contagious itchy and rash-like symptoms that health officials linked to certain parasites of birds and animals. Health officials did extensive testing of Greenwood's water at the time. The swimming area remained open and no serious illnesses were reported. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CYCLOSPORIASIS (TEXAS): 17 July 2013, The Dallas Morning News reported today [16 Jul 2013] that Dallas County [Texas] health officials are hunting for the source of a potential cyclosporiasis outbreak. A total of 8 confirmed cases of foodborne illness have been attributed to Cyclospora cayetanensis, a protozoan that causes "frequent and sometimes explosive bowel movements," according to the Mayo Clinic. Of course, those who are exposed to the critter won't show symptoms for about a week -- a fact that demonstrates the difficulty in tracking food-borne illnesses, since most people associate their symptoms with whatever they ate the night before. Imagine, your favorite burger chain takes the blame when it was really the contaminated raspberries you stole from the office fridge last week that have you doubled over. Most people can't remember what they ate 2 days ago. Dallas County officials are involved in an ongoing investigation, but they'll have their work cut out for them. The only way to confirm an infection is through fecal analysis -- something most patients would rather avoid. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

VIBRIO PARAHAEMOLYTICUS (USA): 16 July 2013, Three people became sick recently after eating raw oysters collected from the same private grounds off Fisherman Island on Virginia's Eastern Shore. They ate the oysters at restaurants in Massachusetts and Maryland, victims of a pathogen that grows naturally in warm waters, known as Vibrio parahaemolyticus. It typically hits unlucky consumers with vomiting, diarrhea and other stomach ailments. In one of the 3 reported cases, the person was ill for 10 days, said Keith Skiles, an oyster sanitation specialist with the Virginia Department of Health. Skiles said Virginia has never experienced "an outbreak" of this kind before, defined by national rules as more than 2 cases of the infection stemming from the same waters. "We hope it never gets us again," Skiles said on Mon 15 Jul 2013, 3 days after the health department announced it was closing down the Fisherman Island waters for the next year. A news release issued did not mention the word "outbreak," saying instead the closure was

part of an "emergency." The incident opens the door to renewed debate about allowing oysters to be harvested in warm summer months. On public grounds, oystering is limited to the fall and winter, when Vibrio and other potentially dangerous pathogens are not active. But the state grants oyster farmers the right to harvest from their private beds any time they want to, as long as they take precautions against contaminants that might be present. Farmers, for example, can ice down their catches immediately or work only in the cooler, morning hours before a 10 am curfew, according to state regulations. Skiles said the tainted oysters were gathered from private grounds around Fisherman Island in mid-May 2013, not far from where the Chesapeake Bay Bridge-Tunnel empties onto Northampton County. They appear to have been collected in compliance with state regulations, he said, and were eaten several weeks ago in mid- or late-June 2013 after being shipped north. The word "outbreak" is one that states and seafood merchants work overtime to avoid, knowing how it quickly can sink reputations and kill consumer demand. The Virginia Marine Products Board, which markets state seafood, said it was unaware as of 16 Jul 2013 of the Fisherman Island outbreak but would seek information right away. It said it had not received any calls from other businesses in other states. Several seafood buyers contacted said they, too, had not heard of the incident but expressed concern that word would spread quickly. The closed waters around Fisherman Island affect only oysters and clams, not fish. It is possible the area could be reopened sooner than a year, Skiles said, depending on what water quality samples showed. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

VIBRIO VULNIFICUS (LOUISIANA): 16 July 2013, A Louisiana man died after contracting a "flesh-eating" bacterium while fishing in the Gulf of Mexico. The Town Talk reports the bacterium known as Vibrio vulnificus, which is found in warm seawater, killed the 83-year-old man after his open wound got infected when water splashed on him during a fishing trip. "It thrives in warm water," Dr. Tina Stefanski of the Louisiana Department of Health and Hospitals told KATC-TV. "So, you can imagine in the summer months, we see an increased number of this type of bacteria in warm salt water." The department is warning swimmers and beach-goers to be careful in the warm water, especially ones with open wounds. "We certainly do not mean to discourage people from enjoying water activities, but we want them to understand the potential risks involved," Department Secretary Kathy Kliebert told The Town Talk. "DHH works with other state and local partners to monitor and test beach water to inform residents of the water quality, and we hope residents will heed posted beach advisories when they see them." Three others swimming in the Louisiana Gulf coast were sickened from the bacterium. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SHIGELLOSIS, SEROTYPE SONNEI (USA): 15 July 2013, The Rhode Island Department of Health is urging residents to protect themselves after nearly 150 people have reported becoming sick with shigellosis. Earlier this month [July 2013], 134 cases of the illness were reported from people who swam at Spring Lake Beach on 4 Jul 2013. An additional 14 cases were reported from people who recently swam at Wallum Lake, and more cases were reported from Rhode Island residents who swam in Massachusetts. The Director of Health, Michael Fine, recommends washing your hands frequently and not swimming if you have been sick with diarrhea in the past 48 hours. Most people with shigellosis develop diarrhea, fever, and stomach cramps starting one to 3 days after exposure. Most infections are not severe and last between 48 and 72 hours. The Department of Health investigated an outbreak of the gastrointestinal sickness after people were sickened after swimming in Burrillville. The beach has since been reopened to swimmers. People who develop symptoms of diarrhea, abdominal pain, fever or vomiting should contact their doctor. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

MERS-COV (EASTERN MEDITERRANEAN): 19 July 2013, WHO has been informed of 6 additional laboratory-confirmed cases of infection with Middle East respiratory syndrome coronavirus (MERS-CoV). Of these, 2 cases have been reported from Saudi Arabia and 4 from the United Arab Emirates (UAE). Both the cases in Saudi Arabia have mild symptoms and are not hospitalized. They are from Asir region. The 1st case is a 26-year-old man who is a close contact with a previously laboratory-confirmed case, and the 2nd case is a 42-year-old woman who is a health care worker. In the UAE, the 4 cases are health care workers from 2 hospitals in Abu Dhabi who took care of an earlier laboratory-confirmed patient. Of these, 2 cases, a 28-year-old man and 30-year-old woman, did not develop symptoms of illness. The other 2 cases, both women of 30 and 40 years old, had mild upper respiratory symptoms and are in stable condition. Globally, from September 2012 to date [18 Jul 2013], WHO has been informed of a total of 88 laboratory-confirmed cases of infection with MERS-CoV, including 45 deaths. Based on the current situation and available information, WHO encourages all Member States to continue their surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns. Health care providers are advised to maintain vigilance. Recent travelers returning from the Middle East who develop SARI should be tested for MERS-CoV as advised in the current surveillance recommendations. Specimens from patients' lower respiratory tracts should be obtained for diagnosis where possible. Clinicians are reminded that MERS-CoV infection should be considered even with atypical signs and symptoms, such as diarrhea, in patients who are immunocompromised. Health care facilities are reminded of the importance of systematic implementation of infection prevention and control (IPC). Health care facilities that provide care for patients suspected or confirmed with MERS-CoV infection should take appropriate measures to decrease the risk of transmission of the virus to other patients, health care workers and visitors. All Member States are reminded to promptly assess and notify WHO of any new case of infection with MERS-CoV, along with information about potential exposures that may have resulted in infection and a description of the clinical course. Investigation into the source of exposure should promptly be initiated to identify the mode of exposure so that further transmission of the virus can be prevented. WHO does not advise special screening at points of entry with regard to this event nor does it currently recommend the application of any travel or trade restrictions. WHO has convened an Emergency Committee under the International Health Regulations (IHR) to advise the Director-General on the status of the current situation. The Emergency Committee, which comprises international experts from all WHO Regions, unanimously advised that, with the information now available, and using a risk-assessment approach, the conditions for a Public Health Emergency of International Concern (PHEIC) have not at present been met. (Emerging Pathogens are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

ANTHRAX (TAJIKISTAN): 17 July 2013, Anthrax virus (bacteria) is spreading over the northern regions of Tajikistan. On [16 Jul 2013], 2 more infected people were registered in Bobojonghafur district [Ghafurov district] of Tajik Sogdiysk region [Sogd province], Asia-Plus reported with the reference to deputy chief physician of the regional Sanitary-Epidemiological Service, Nasibdzhon Ikromov. According to Ikromov, the Center for Sanitary and Epidemiological Supervision takes measures to prevent the spread of the infectious diseases in accordance with the approved action plan. [However, anthrax is not contagious, though infectious. - Mod.MHJ] Meanwhile, 8 anthrax cases were detected within the country, including 4 in Aini district [previously only 2], 2 in Panjakent district [previous report had 4] and 2 more in Bobojonghafur [Ghafurov] district, he said. One of the people infected with anthrax has died in the infectious disease hospital. According to Ikromov, 33 people in the Ayni district, as well as 28 people in Panjakent and 6 in Bobojonghafur [Ghafurov] districts had contact with the source of infection (the infected animal). All these people are under medical observation. (Anthrax is listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

CRYPTOSPORIDIOSIS (NEW ZEALAND): 17 July 2013, There had been 24 cases of cryptosporidiosis [in Taranaki region] reported since the start of the year [2013] compared with none for the same period last year [2012], Dr Jonathan Jarman said yesterday [16 Jul 2013]. "Cryptosporidium is not normally a serious disease but it can be dangerous for people with lowered immunity," he said. "Diarrhea and tummy cramps for 2 weeks aren't much fun." "Some of the cases were children but half were adults, and similar outbreaks have also been seen in other parts of New Zealand. "The main symptoms are diarrhea, often watery, stomach cramps, lack of appetite and weight loss," Dr. Jarman said. The illness may last 2 weeks or more. There is no treatment except for making sure that the patient does not become dehydrated. The illness is caused by a tiny parasite found in the guts of birds, fish, reptiles (such as geckos and turtles), humans and animals such as cattle, sheep, cats and dogs. It is passed on in the feces of infected animals and humans. The usual risk factors for cryptosporidiosis are living on a farm and having contact with farm animals. "However, some cases in Taranaki became unwell after recently swimming in a pool," Dr. Jarman said. "It is important that people with recent tummy bug symptoms stay away from swimming pools, otherwise they may spread the illness to others," he said. The bugs are excreted by sick people for several weeks once they have recovered from the illness. People should not go swimming in a pool if they have diarrhea. Wait until at least 2 weeks after the symptoms have gone. See a doctor if the symptoms are severe, if worried or if the illness does not get better after 2-3 days. Wash hands thoroughly after contact with animals or animal feces, after caring for people with diarrhea, after going to the toilet, and before and during food preparation. Use plenty of soap, clean under your fingernails, rinse your hands well and dry them on a clean towel. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable